APPENDIX G

TCC-Tri-County Clinical • 5339 North Interstate 35 Frontage Road Ste 100, AUSTIN TX 78723-2428

B[redacted], K[redacted] (id #[redacted], dob: [redacted]2014)

Seton Healthcare Family

Date: 06/10/2019

RE: K[redacted]
DOB: [redacted]2014

To Whom it may concern,

Attached are the records you requested.

Sincerely,

Tri-County Clinical

Clinical Documents

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BRIEF PSYCHOLOGICAL EVALUATION

CONFIDENTIAL

Client:	K[redacted] E[redacted]
DOB:	[redacted]2014
Age at Testing:	5 years, 0 months
Date of Testing:	04/24/2019
Date of Report:	05/17/2019
Examiners:	Briana H. Brukilacchio, M.Ed Meredith I. Brinster, PhD

REASON FOR REFERRAL

K[redacted] was referred by his treating nurse practitioner, Cordelia Garcia, FNP-C. A psychological evaluation was requested to provide information regarding his current social and emotional functioning and assess for the presence of autism spectrum disorder.

SOURCES OF INFORMATION

- Review of Occupational Therapy Evaluation and Plan of Care (Kid Ventures Therapy) dated 10/09/18
- Review of Medical Record (Pediatric Associates of Austin) dated 01/29/19
- Review of Medical Visit Summary (Developmental Behavioral Pediatrics) dated 04/02/19
- Review of New Patient Parent Questionnaire (Developmental Behavioral Pediatrics) dated 02/11/19
- Review of Patient Questionnaire (Developmental Behavioral Pediatrics) dated 04/02/19
- Review of Individualized Applied Behavior Analysis Programs (Little Behavior Consulting) dated 03/19 & 04/19
- Review of VB-MAPP Milestones (Little Behavior Consulting) dated 03/27/19
- Clinical interview with K[redacted]'s mother (A[redacted] E[redacted])
- Behavioral observations
- Gilliam Autism Rating Scale, 3rd Edition (GARS-3), parent report, teacher report
- Vineland Adaptive Behavior Scales, Third Edition (VABS-3), parent report
- Autism Diagnostic Observation Schedule, 2nd Edition (ADOS-2), Module 3

BACKGROUND

K[redacted] is a 5-year-old male who lives with his parents and younger sister in Austin, TX. English is spoken in the home. Both parents hold Bachelor of Science (B.S.) degrees. His father is a software engineer; his mother worked in software as well but is currently not working due to K[redacted]'s behavioral difficulties and related challenges in sustaining educational enrollment.

Developmentally, K[redacted] was the product of a full-term pregnancy (41 weeks) and Caesarian-section delivery, weighing 8 pounds, 13 ounces at birth. Complications during pregnancy included stalled labor. K[redacted] had a normal newborn nursery stay, passed newborn hearing and metabolic screeners, and met developmental milestones ahead of schedule. As an infant, K[redacted] reportedly had a positive temperament though he exhibited some separation anxiety, difficulty self-soothing, and hyper-sensitivities to auditory stimuli.

K[redacted]'s medical history is positive for an unspecified emotional and behavioral disorder and developmental coordination disorder by Dr. Ashley Gonzalez, MD at Pediatric Associates of Austin. K[redacted] was also reportedly diagnosed with Social Pragmatic Communication Disorder in June 2018 by a speech pathologist (report not available for review). Immunizations are up to date. K[redacted] has been in overall good health without any significant illnesses, injuries, or surgeries. Hearing and vision have been tested and are within normal limits. K[redacted] is not currently prescribed any medications. Family history is notable for ADHD, anxiety/panic, coordination problems, disordered eating, migraine headaches, cancer, and hearth rhythm problems.

With regard to K[redacted]s personality and interests, his mother describes him as very creative, musically talented, helpful, funny, engaging, highly aware of the world around him, and strongly interested in science. She reports that he enjoys playing with friends, has an amazing memory, an advanced vocabulary, and loves music. K[redacted] reportedly has synesthetic experiences with color and music, for example he may ask for his mother to adjust the music by saying, "stop that at the orange explosion." K[redacted] is also a very talented drummer with "savant-like" musical skills. He reportedly beat-boxes and drums/taps on surfaces very often.

Behaviorally, a tendency for rough physical play reportedly emerged at approximately 2 years of age. K[redacted] has difficulty observing personal space and can become aggressive towards peers and parents. K[redacted]s mother reports that his emotional and behavioral reactions are extreme. His peers reportedly find these reactions unnerving and even highly skilled teachers find his behavior difficult to manage in a classroom setting. K[redacted] also exhibits behavioral rigidity in his eating habits, musical preferences, social interactions, and during transitions. His mother reports that he has to play in a specific way or else he will become upset and he enjoys collecting items (e.g. bugs, shells, flowers, rocks). She reports that he fidgets or squirms very often, gets up when he is expected to remain seated, and excessively runs about or climbs when it is not appropriate to do so. He often argues with adults, refuses to follow requests and rules, and blames others for his behavior. Overall, K[redacted]'s mother reports that his behavior is sweet and loving 60% of the time, hyperactive, overly silly, and difficult to redirect about 35% of time, and highly dysregulated about 5% of the time, at which point he often becomes physically aggressive, disruptive, or argumentative.

Related to sensory interests and aversions, K[redacted] is easily overstimulated by physical touch and auditory input. He also seeks objects with particular tactile properties (e.g. "squishy things") and items that spin. Sensory behaviors are discussed in additional detail within the Previous Evaluations section of this report.

With regard to communication and social behavior, K[redacted] has difficulty recognizing nonverbal cues, observing personal space, sharing, sustaining play with peers, and engaging in conversation across a flexible range of topics. He is able to focus independently on projects that are of interest to him but has a difficult time regulating his behavior in group settings. Social behaviors are discussed in additional detail within the Previous Evaluation and Test Results/Interpretation sections of this report.

K[redacted] is currently enrolled in a half-day pre-kindergarten program at Let It Shine Enrichment Academy, which specializes in working with "spirited children." Prior to starting Pre-K at Let It Shine, K[redacted] was asked to leave three schools due to behavioral outbursts and sensory sensitivities. His mother reports that he did not do well in unstructured settings but has responded well to the accommodations (e.g. headphones) and supports available to him in this specialized setting.

PREVIOUS EVALUATIONS

K[redacted] received an occupational therapy evaluation at age 4 by Megan Chadwick, MS, OTR at Kid Ventures Therapy. Results of that evaluation suggest that K[redacted] has a variety of sensory seeking and aversion behaviors. Specifically, his sensory-seeking behaviors include careful visual examination of objects, an interest in listening to certain sounds repeatedly (e.g. toilet flushing over and over), a strong need to touch people and objects, tasting of non-food items, seeking out proprioceptive activities such as pushing, pulling, lifting, and jumping, and occasional vestibular activities such as rocking or bouncing in his seat. K[redacted]s sensory-aversions include strong negative reactions to water temperature and physical touch, distress in response to unexpected or overwhelming sounds, and pickiness with tasting certain foods. K[redacted] also has some under-responsiveness related to touch (which the examiner noted may drive his hyper-physical behavior at times). For example, he seeks pressure and applies too much for certain tasks, has a history of toe-walking, and sometimes appears to enjoy activities that should be painful (e.g. crashing on the floor, head-banging). In summary, the evaluator found that K[redacted] has "difficulty with modulation of sensory information which affects his emotional response, behavior, and sensory-based motor abilities." For additional information see the full report dated 10/9/2018.

In March and April 2019 K[redacted] was evaluated for the purposes of creating an Individualized Applied Behavior Analysis Program by Amanda Little, Ph.D., BCBA-D, LBA and Lindsey Hamm, M.S. at Little Behavior Consulting, LLC. Results of that evaluation suggest that K[redacted] requires prompting to engage in sustained reciprocal conversation with peers, has difficulty sitting with a group, does not consistently return or initiate greetings or take conversational turns in the context of a structured game, and has difficulty regulating his emotional reactions, accepting changes in routine, and adapting to unexpected changes. He also requires prompting to introduce himself to someone new, participate in a conversation, use appropriate volume, maintain eye contact, and orient his body towards the appropriate person. He has difficulty identifying nonverbal cues and responding to them appropriately. For additional information see the full reports dated 3/2019 and 4/2019.

GENERAL TEST BEHAVIORS & OBSERVATIONS

K[redacted] was evaluated during one office visit to which he was accompanied by his mother. He separated easily from his mother after she provided pre-corrections and allowed some time for him to acclimate to the office environment. He

expressed interest in the assessment materials although he had strong opinions regarding tasks in which he wanted to participate. Further detail regarding his behavior is described in the ADOS-2 section to follow.

TEST RESULTS & INTERPRETATION

The Autism Diagnostic Observation Schedule, Second Edition – Module 3 (ADOS-2) was administered to evaluate the presence of observable behaviors often associated with a diagnosis of autism. This assessment provides a sample of an individual's functioning within a semi-structured, one-on-one environment including an interaction with the examiner that lasts approximately 40 minutes. It includes opportunities to observe behaviors during episodes of make-believe and interactive play, conversations, and other activities. Tasks are intended to capture behavior patterns associated with two domains: (1) Social Affect and (2) Restricted and Repetitive Behaviors. Module 3 is appropriate for children and younger adolescents who are verbally fluent (i.e. produce a range of flexible sentences beyond their immediate context).

Validity: The appropriate ADOS-2 module was selected according to K[redacted]'s age and language level. The assessment was performed and rated by an advanced psychology extern with research reliability on the ADOS-2, Briana Brukilacchio, M.Ed., under the direct supervision of a licensed psychologist, Dr. Meredith Brinster, Ph.D. Functional vision and hearing appeared appropriate for testing purposes. Cultural and developmental considerations were made while selecting the measure, administering the module, and interpreting the results. Minor adaptations to the protocol were made in order re-engage K[redacted] during non-preferred activities (e.g. questions were asked while he continued to explore the break activities). While these results are believed to be a valid representation of K[redacted]'s level of functioning at the time of his evaluation, ADOS-2 scores are meant to be considered alongside additional sources of information in order to provide a complete picture of autism symptomology.

Social Affect refers to a cluster of social interaction and social communication behaviors associated with autism. Behaviors measured within this domain include social-emotional reciprocity, non-verbal communication strategies and behavior needed for the development and maintenance of relationships. During the ADOS-2, K[redacted] used sentences in a largely correct fashion. He occasionally mumbled, although his volume, rhythm, rate, and intonation were otherwise normal. K[redacted]'s use of language and communication was appropriate for his age with slight weaknesses noted in conversational turn-taking. K[redacted] directed a range of facial expressions towards the examiner, effectively used nonverbal and verbal means to make clear social overtures, and frequently sought the examiner's attention. There were subtle weaknesses related to the amount and quality of his social responses, which tended to be somewhat limited, inconsistent, and often negative. He had more pronounced difficulties with eye contact and expressed little insight into typical social situations, relationships, and emotions. Overall, K[redacted] demonstrated well-developed language and communication skills but had better developed social interaction skills when initiating a social exchange than when responding to the examiner.

Restricted and Repetitive Behavior refers to a cluster of restricted, repetitive patterns of behavior, interests, or activities that are associated with autism. Behaviors falling within this domain include stereotyped or repetitive speech and motor mannerisms, excessive adherence to routines, restricted or fixated interests, and sensory sensitivities. During the ADOS-2, K[redacted] visually inspected a metallic disc and repeatedly requested access to "squishy things." He also aligned markers and puzzle pieces up very carefully, though he did not become visibly distressed when the materials were moved or rearranged. No instances of complex mannerisms, self-injurious behavior, or excessive interest in highly specific topics were observed during the ADOS-2. A repetitive behavior of drumming/tapping on the table was observed during the assessment. Overall, K[redacted] demonstrated some visual and tactile sensory-seeking behavior and slight compulsiveness in his arrangement of materials.

Interpretation of Results: Scoring for the ADOS-2 is divided into two main sections: (1) Social Affect and (2) Restricted and Repetitive Behaviors. Results are obtained by comparing behavior observed during the ADOS-2 to scoring criteria. Obtained scores are then totaled and compared to specific cut-off criteria and a severity metric that captures the degree of autism-related symptoms observed during the ADOS-2. For individuals with a similar age and language level to K[redacted], scores between 7-8 indicate an elevated concern for autism and scores of 9 or above indicate a clinically significant concern for autism. K[redacted]'s behavior during the ADOS-2 assessment resulted in a total score of 9. Compared to children with a similar age and language level, this indicates a moderate level of autism-related symptoms and a clinically significant concern for autism.

AUTISM RATING SCALES

K[redacted]'s mother and teacher completed the Gilliam Autism Rating Scale, Third Edition (GARS-3). The GARS-3 screens for the presence of autism symptoms and provides a probability index for whether an individual will meet diagnostic criteria for autism. Both raters endorsed clinically significant emotional over-responsivity to everyday situations, such as requiring an excessive amount of reassurance if things are changed or go wrong and having tantrums when he doesn't get his way. Raters also endorsed that K[redacted] has idiosyncratic interests, characteristics, and cognitive abilities. For instance, he reportedly displays superior knowledge and skill in specific subjects, displays excellent memory, and has intense, obsessive interests in specific intellectual subjects. His teacher additionally endorsed some concerns

related to K[redacted]'s verbal communication, including unusual intonation and idiosyncratic use of words and phrases. Results from parent and teacher rating scales indicate that K[redacted] "very likely" has autism spectrum disorder.

ADAPTIVE BEHAVIOR

K[redacted]'s mother completed the Vineland Adaptive Behavior Scale, Third Edition (VABS-3). The VABS-3 assesses an individual's proficiency in completing daily tasks required for personal and social sufficiency. Overall, his adaptive behavior is rated in the moderately low range (SS=77). However, this does not capture the variability in his skills. For instance, K[redacted] has strengths in daily living and motor skills while his communication and socialization are apparent weaknesses.

SUMMARY

K[redacted] is a 5-year-old male who was referred for an autism evaluation. He has many strengths and resources including an engaging personality, good relationships with his family members, and an interest in peers. His mother describes him as very creative, musically talented, helpful, funny, engaging, highly aware of the world around him, and strongly interested in science. She reports that he enjoys playing with friends, has an amazing memory, an advanced vocabulary, and loves music. K[redacted] is also a very talented drummer with "savant-like" musical skills. In the context of these strengths and talents, K[redacted] demonstrates the following areas of weakness:

Social communication and social interaction: K[redacted]'s mother reports significant delays in his communication and socialization skills on a norm-referenced measure of adaptive behavior. Parents, teachers, and therapists have observed difficulties in his interactions with peers including difficulty sharing, responding appropriately, and integrating nonverbal and verbal behaviors. During a one-on-one assessment with the examiner, K[redacted] displayed difficulties with aspects of social interaction such as conversational turn-taking and demonstrated limited insight into typical social relationships or emotions.

Restricted or repetitive patterns of behavior: K[redacted]'s mother and teacher report extreme emotional reactions to everyday events including marked difficulty while transitioning from preferred tasks or topics and coping with changes in his routine. K[redacted] displays strong interests in specific intellectual topics and difficulty flexibly engaging in conversations. During a one-on-one assessment with the examiner, K[redacted] engaged in sensory-seeking and slightly compulsive behavior.

Sensory perception: K[redacted] has a number of sensory-seeking and sensory-avoidant behaviors which likely underlie a significant portion of his behavioral outbursts. Additionally, K[redacted] likely has color-auditory synesthesia, which is a neurological phenomenon in which an individual sees colors in response to auditory input. Research indicates that individuals with synesthesia often perform very well on measures of intelligence and memory, and often gravitate towards creative fields. Rates of synesthesia are higher among individuals with autism than in the general population.

Externalizing behaviors: K[redacted]'s mother reports that he sometimes becomes aggressive or disruptive in the home and school environments. K[redacted]'s sensory experiences and behavioral rigidity are believed to underlie the extreme emotional outbursts that are frequently observed at home and school. Therefore, these behaviors should not be considered expressions of disobedience, vengefulness, or purposeful violence. Rather, such behaviors are likely secondary to significant anxiety experienced from K[redacted]'s cognitive rigidity and sensory experiences.

DIAGNOSTIC IMPRESSIONS

This evaluation was conducted to provide information regarding K[redacted]'s current social and emotional functioning and assess for the presence of autism spectrum disorder. Diagnostic impressions are limited to the scope of this evaluation. This report is to be used in conjunction with any additional school-based evaluations, as well as diagnostic impressions provided by other treating professionals.

K[redacted] demonstrates clear differences in communication, social interaction, sensory processing, and repetitive behaviors consistent with a diagnosis of autism spectrum disorder. K[redacted]'s social communication behaviors are relatively well-developed compared to same-aged peers with autism and his restricted and repetitive behaviors manifest primarily through behavioral rigidity, extreme distress to small changes or events, and sensory abnormalities. As outlined by the DSM-5, the severity of current symptoms is based on the level of support he will need through intervention, accommodations, and modifications and may fluctuate over time. Based on his current presentation, K[redacted] will require Level 1 support for social communication and Level 2 support for restricted and repetitive behavior patterns.

Autism is a neurodevelopmental disorder indicating that an individual's brain was built and functions slightly differently than their same-aged peers. This is a lifelong diagnosis that manifests differently throughout development, therefore K[redacted]'s strengths and weaknesses are likely to change over time. His verbal skills, creativity, and strong interest in science suggest that he will excel in certain areas. However, his weaknesses in behavioral regulation, peer interaction, and emotional control will likely negatively impact his ability to make and maintain friendships and learn in a classroom setting without additional support. Aspects of executive functioning are expected to develop slowly over time and will assist K[redacted] in managing his emotional and behavior reactions. Given that K[redacted] is motivated to make friends, but he

struggles in this area, he may be at-risk for developing internalizing symptoms in the future including social anxiety or feelings of low self-esteem. As such, parents and teachers should monitor for such symptoms on a regular basis.

Each individual with autism has a unique profile and K[redacted]s constellation of strengths and symptoms is especially unusual. It may be tempting to conceptualize K[redacted]'s behavioral outbursts as evidence of an externalizing disorder, but the antecedents, characteristics, and frequency of his outbursts indicate that they are primarily triggered by sensory experiences, transitions, or otherwise related to his difficulties with perspective-taking and social communication. It will be crucial for K[redacted]'s teachers and therapists to consider how autism symptoms drive many of his behaviors, and not to underestimate the impact of this neurodevelopmental disorder on his daily functioning.

DSM- 5 DIAGNOSIS (ICD-10-CM Code):

F84.0 Autism spectrum disorder
Requires Level 1 support for social communication behaviors
Requires Level 2 support for restricted, repetitive behavior patterns

RECOMMENDATIONS

1. If in a public school, consideration for accommodations under the state of Texas Education Agency Handicapping Condition of Autism will be necessary. These accommodations will provide K[redacted] with extra services to maximize his school success; however, the ARD committee will determine which strategies will be placed in K[redacted]s IEP. Some of the strategies, which are based on the Commissioner's Rule Related to Autism TAC 89.1055(e), are listed below:
    a. Extended educational programming. Examples include extended day and/or extended school year services that consider the duration of program/settings based on assessment of behavior, social skills, communication, academics and self-help skills.
    b. A small class size that allows for more individualized attention by teachers. The staff-to-student ratio should be appropriate to identified activities and as needed to achieve social/behavioral progress based on K[redacted]'s developmental and learning level.
    c. Daily schedules reflecting minimal unstructured time and active engagement in learning activities. Examples include lunch, snack, and recess periods that provide flexibility within routines; adapt to individual skills levels; and assist with schedule changes, such as changes involving substitute teachers and school-wide activities.
    d. Positive behavior support strategies based on relevant information. Examples include a behavior intervention plan developed from a functional behavior assessment that uses current data related to target behaviors and addresses behavioral programming across home, school, and community-based settings.
    e. Futures planning, beginning at any age, for integrated living, work, community, and educational environments that considers skills necessary to function in current and post-secondary environments.
    f. Parent/family training and support, provided by qualified personnel with experience in autism spectrum disorders (ASD).
    g. Communication interventions, including language forms and functions that enhance effective communication across settings.
    h. Social skills support and strategies based on social skills assessment/curriculum and provided across settings. Examples include trained peer facilitators, video modeling, social stories and role playing.
    i. Professional educator/staff support. Examples include training provided to personnel who work with the student to ensure correct implementation of techniques and strategies described in the IEP.
    j. Teaching strategies based on peer-reviewed, research-based practices for students with ASD. Examples include those associated with discrete-trial training, visual supports, applied behavior analysis, structured learning, augmentative communication, or social skills training.

2. K[redacted]'s caregivers are encouraged to review information about ASD from reputable sources such as Autism Speaks, Association for Science in Autism Treatment, and Autism Science Foundation.

3. Behavior therapy based on the principles of applied behavior analysis (ABA) is the recommended treatment approach for skill weaknesses and behavior challenges associated with ASD. Behavioral parent training is highly recommended as a part of K[redacted]'s program. K[redacted]'s mother has connected with an ABA provider in the community. Additional referrals can be provided upon request.

4. To help K[redacted] with self- regulation, praise him for appropriate flexibility with changes and behavior regulation. At times children who struggle with self-regulation receive more attention for negative behavior and miss the attention for positive behaviors. Adults who work with K[redacted] are encouraged to use praise that is genuine, specific, and more frequent than correction. Adults should aim to provide about five positive statements for every correction/re-direction throughout her day.

a. See Stephen Flora's article, Praise's magic reinforcement ratio: Five to one gets the job done published in The Behavior Analyst Today. A quick summary is available at http://www.pbisworld.com/tier-1/acknowledging-positive-behavior/).

5. K[redacted]'s ASD will affect his functioning across settings. As a result, he may benefit from social narratives. Social narratives are an established evidence-based intervention for children preschool through middle school-age. Social narratives can help K[redacted] prepare for new situations or to remind him of behavioral expectations in non-routine situations (going to the doctor, going to the dentist, etc.). Narratives should describe social situations using relevant and developmentally appropriate pictures and descriptions of behavior expectations. Social Stories®, developed by Carol Gray, is a commercially available social narrative intervention. For additional information on social narratives see the article, "Teaching social skills through social narratives: Another evidence-based practice" by the Virginia Department of Education's Training & Technical Assistance Center.

6. K[redacted]'s family is encouraged to continue to promote healthy sleep habits to optimize his cognitive resources during the day. A consistent bedtime, in conjunction with turning down the lights and reducing exposure to bright screens later in the evening can help promote sleep. Exercise and diet are also important in optimizing an individual's resources.

7. K[redacted]'s parents are encouraged to discuss these results with his treating nurse practitioner, as well as other professionals involved in his care.

8. Texas Parent to Parent (www.txp2p.org) provides support, information, and education to families of children of all ages who have disabilities or chronic illness. The Texas Parent to Parent staff are parents of children with disabilities, chronic illness, or special health care needs. K[redacted]'s parents are encouraged to connect with this family support group (512-458-8600) for current and future needs.

9. Given the nature of K[redacted]'s neurodevelopmental disorder, and his potential to improve in areas of functioning, a re-evaluation of his progress with norm-referenced, standardized assessments is recommended in approximately three years to update recommendations.

The current evaluation is based on information provided through 4/24/2019. Should any further information be provided, the conclusions made in this report may be reconsidered. It was a pleasure to have the opportunity to work with K[redacted] and his family.

Briana H. Brukilacchio, M.Ed.
Advanced Psychology Extern
Educational Psychology

Meredith Brinster, Ph.D.
Supervising Licensed Psychologist (TX# 37355)
Pediatric Developmental Psychology

B[redacted], K[redacted]

SUMMARY OF SCORES

Please note: The numeric data presented below are only intended for use by qualified professionals and should not be interpreted without consideration of the information contained in the previous sections of this report.

Standard Score	Scaled Score	T Score	Z Score	Percentile	Stanine	Descriptive Range
≥ 130	16+	70+	2.0+	98+	9	Very Superior
120-129	14-15	63-69	1.34-1.99	91-97	8	Superior
110-119	12-13	57-62	0.67-1.33	75-90	7	High Average
90-109	8-11	43-56	(-0.67)-0.66	25-74	4-6	Average
80-89	6-7	37-42	(-1.33)-(-0.66)	9-24	3	Low Average
70-79	4-5	30-36	(-2.0)-(-1.32)	2-8	2	Low
≤ 69	0-3	≤ 29	≤ (-2.1)	<1	1	Very Low

ADOS-2

Domain	**Total Score**	**Level of ASD-Related Symptoms**
Total Score	**9**	**Moderate**
Social Affect	7	---
Restricted and Repetitive Behavior	2	---

GARS-3

Index/Scale	**Mother** Scaled Score/**Standard Score**	**Occupational Therapist** Scaled Score/**Standard Score**
Restricted/Repetitive Behaviors (RB)	11	11
Social Interaction (SI)	6	4
Social Communication (SC)	7	11
Emotional Responses (ER)	14	14
Cognitive Style (CS)	14	12
Maladaptive Speech (MS)	9	12
Autism Index	**102**	**106**

Vineland-3: Parent Form *[V Scaled Score Mean = 15, SD = 3]*

Composite / Scale	**Standard Score**/ V Scaled	**Percentile**	**Description**	**Age Equivalent**
Communication	**81**	10	Moderately Low	
Receptive	10			2:3
Expressive	13			3:10
Written	13			4:3
Daily Living Skills	**87**	19	Adequate	
Personal	13			3:8
Domestic	13			3:0
Community	13			3:4
Socialization	**70**	2	Low	
Interpersonal Relationships	11			2:0
Play and Leisure	9			1:7
Coping Skills	8			<2:0
Adaptive Behavior Composite (ABC)	**77**	6	Moderately Low	